KAMALA D. HARRIS
Attorney General of California
JAMES M. LEDAKIS
Supervising Deputy Attorney General
DESIREE I. KELLOGG
DEPUTY ATTORNEY GENERAL
State Bar No. 126461
110 West "A" Street, Suite 1100
San Diego, CA 92101
P.O. Box 85266
San Diego, CA 92186-5266
Telephone: (619) 645-2141
Facsimile: (619) 645-2061
Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against: **MARION ELAINE GAMUNDOY** **aka MARION ELAINE McGINN** **22854 Wren Street** **Grand Terrace, CA 92313** **Registered Nurse License No. 298775** Respondent.	Case No. 2011-783 **FIRST AMENDED ACCCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this First Amended Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about December 31, 1978, the Board of Registered Nursing issued Registered Nurse License Number 298775 to Marion Elaine Gamundoy, also known as Marion Elaine McGinn (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on November 30, 2012, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2750 of the Code provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811, subdivision (b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

STATUTORY PROVISIONS

6. Section 2761 of the Code states:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct . . .

7. Section 2762 of the Code states:

> In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:
>
> (a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.
>
> . . . .
>
> (e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section.

8. Section 4022 of the Code states

"Dangerous drug" or "dangerous device" means any drug or device unsafe for self-use in humans or animals, and includes the following:

(a) Any drug that bears the legend: "Caution: federal law prohibits dispensing without prescription," "Rx only," or words of similar import.

(b) Any device that bears the statement: "Caution: federal law restricts this device to sale by or on the order of a _____," "Rx only," or words of similar import, the blank to be filled in with the designation of the practitioner licensed to use or order use of the device.

(c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006.

9. Section 4060 of the Code states, in pertinent part, that no person shall possess any controlled substance, except that furnished to a person upon the prescription of a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor.

COSTS

10. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

DRUG

11. Hydromorphone, also known by the brand name Dilaudid, is a Schedule II controlled substance as designated by Health and Safety Code Section 11055, subdivision (b)(1)(K), and is a dangerous drug pursuant to Business and Professions Code section 4022.

FACTUAL ALLEGATIONS

Division of Investigation Case No. 10-01516-RN

12. Respondent was employed by Loma Linda University Medical Center (LLUMC) from April 26, 2005 to July 2, 2009. Respondent was assigned to the Oncology Unit as a per diem "floater" working 12-hour shifts, as needed.

13. As part of Respondent's orientation, she received training on LLUMC's Operating Policies.

a. The Operating Policy entitled *Medication Administration and Errors* (M-55) required that written (medication) orders be verified before administration to the patient. Medication was not to be administered without a complete order having been written. The goal was to have administration of medications documented within one hour of administration, taking into consideration the nature of the medication and the patient's medical condition. Failure to administer a dose that was specified a certain number of times per day was to be reported as a missed dose rather than as a significant time deviation. The designated physician was to be notified promptly of all medication administration errors.

b. The Operating Policy entitled *Narcotics and Controlled Drugs Management in Patient Care Areas* (R-4) that was in effect at all times stated herein, states that the wastage of narcotics or controlled drugs required that: (1) injectables were to be discarded in the sink; (2) patches were to be flushed down the toilet; (3) lozenges were to be dissolved under hot water; (4) the documentation of the amount given and the amount wasted must be recorded on the Controlled Drug Record or in the automated dispensing cabinet (Accudose[1]); (5) the signature and/or access code of the nurse disposing of the wasted drug; and (6) the signature and/or access code of the nurse witnessing the wasting of the substance. When narcotics or controlled drugs were missing from the locked container, it required: (1) two signatures of authorized persons on the Controlled Drug Record; (2) notification of supervisory personnel; and (3) completion of the Report of Controlled Substance Loss. When substances were missing from Accudose, it required: (1) completion of the discrepancy report by the nurse receiving the systems printout; (2) placement of a report in a designated place with by a pharmacist; (3) completion of a Controlled Substance Loss report; and (4) notification of supervising personnel. Narcotics for individual

[1] "Accudose" is a trade name for the automatic single-unit dose medication dispensing system that records information such as patient name, physician orders, the date and time the medication was withdrawn, and the name of the licensed individual who withdrew and administered the medication. Each user/operator is given a user identification code to operate the control panel. Sometimes only portions of the withdrawn medications are administered to the patient. The portions not administered are referred to as "wastage." Wasted medications must be disposed of in accordance with hospital rules and must be witnessed by another authorized user and recorded in Accudose.

patients were to be returned to the pharmacy when the patient is no longer on the unit, or they are not used within 30 days.

14. In June 2009, the Director of the Oncology Unit was notified that Respondent was observed on numerous occasions accessing patients' records after her shift ended. An audit was conducted of Respondent's charting and several discrepancies involving hydromorphone (Dilaudid) were discovered. A report of Respondent's recent Accudose activity was compared to the information charted on the patients' electronic medication administration record (eMAR). There were numerous discrepancies between the amount of hydromorphone withdrawn from Accudose and what was charted as administered in the patients' respective eMAR's. Although there were charting errors with other medications involved, the majority of the discrepancies involved the charting of hydromorphone.

15. On or about June 24, 2009, the Director met with Respondent to discuss her findings. Respondent was unable to provide a plausible explanation for the discrepancies and suggested that there must have been an Accudose malfunction, or that another nurse was accessing her log-in information. Respondent denied diverting the narcotics for her own use, but admitted that she could have made a few mistakes in her charting. Respondent was placed on administrative leave while the investigation continued.

16. Reviews of Respondent's Accudose narcotic usage and waste reports, nursing notes, and charting in patient eMAR's revealed a significant pattern of unaccounted narcotics for the audit period from May 16, 2009 to June 22, 2009. Respondent's employment with LLUMC was terminated on July 2, 2009.

17. On or about July 21, 2009, LLUMC filed a complaint with the Board alleging that Respondent was suspected of narcotics diversion. The internal review of LLUMC identified 40 separate charting discrepancies. A minimum of 35.6 mg of hydromorphone was unaccounted for as follows:

18. Patient 01887 (May 16, 2009): Hydromorphone 0.2 mg IV inj. was ordered for this patient with a recorded pain scale of "0." Respondent removed 2 mg of hydromorphone from Accudose at 0414 hours. Respondent recorded wasting 1.8 mg hydromorphone at 0415, one

minute after it was removed from Accudose. Respondent did not chart any administration in the patient's eMAR or nursing notes. Hydromorphone 0.2 mg was unaccounted for.

19. Patient 01926 (May 17, 2009): Hydromorphone 0.3 mg IV inj. was ordered for this patient. Respondent removed 1 mg hydromorphone from Accudose at 2213 and did not chart the administration in the patient's eMAR or nursing notes, or record it wasted. One (1) mg of hydromorphone was unaccounted for.

20. Patient 01629 (May 18, 2009): Hydromorphone 1 mg IV inj. was ordered for this patient. Respondent removed 1 mg of hydromorphone from Accudose at 0012 and charted only that patient was "medicated" at 0214. (Note: The patient was medicated in the emergency room at 2330 and was recorded transferred to the Oncology unit at 0030.)

21. Patient 00914 (May 18, 2009): Hydromorphone 0.5 mg IV inj. was ordered for this patient who was not assigned to Respondent. Respondent removed 1 mg of hydromorphone from Accudose at 0354 and did not chart its administration in the patient's eMAR or nursing notes, or record it wasted. One (1) mg of hydromorphone was unaccounted for.

22. Patient 01599 (May 18, 2009): Hydromorphone 0.3 – 0.5 mg IV inj. was ordered for this patient who was not assigned to Respondent. Respondent removed 1 mg of hydromorphone from Accudose at 0354 and did not chart the administration in the patient's eMAR or nursing notes, or record it wasted. The patient's pain level at 0400 was recorded as "0." One (1) mg of hydromorphone was unaccounted for.

23. Patient 06179 (May 20, 2009): Hydromorphone 0.5 – 1 mg IV inj. was ordered for this patient. Respondent removed 2 mg of hydromorphone from Accudose at 0243. Respondent did not chart the administration in the patient's eMAR or nursing notes. Respondent wasted 1 mg hydromorphone at 0246, three minutes after it was withdrawn. One (1) mg of hydromorphone is unaccounted for.

24. Patient 06235 (May 20, 2009): Hydromorphone 0.5 mg IV inj. was ordered for this patient. Respondent removed 1 mg of hydromorphone from Accudose at 0401 and did not chart the administration in the patient's eMAR or nursing notes. Respondent charted "no signs of pain" at 0349. Respondent wasted 0.5 mg at 0402, one minute after it was withdrawn. One-half (0.5)

mg of hydromorphone was unaccounted for. On May 21, 2009, Respondent removed 1 mg of hydromorphone from Accudose at 0048. Respondent did not chart its administration in the patient's eMAR or nursing notes, or record it wasted. A total of 1.5 mg hydromorphone was unaccounted for.

25. Patient 01730 (May 21, 2009): Hydromorphone 0.5 – 1 mg IV inj. was ordered for this patient. At 0358, Respondent removed 1 mg of hydromorphone from Accudose at 2147 and did not chart its administration in the patient's eMAR or nursing notes. Respondent wasted 0.7 mg hydromorphone at 0359, one minute after it was withdrawn. At 0927, Respondent removed 1 mg of hydromorphone from Accudose and did not chart its administration in the patient's eMAR or nursing notes, or record it wasted. At 1106, Respondent removed 1 mg of hydromorphone from Accudose at 2147 and did not chart its administration in the patient's eMAR or nursing notes. Respondent wasted 0.7 mg hydromorphone at 1108, two minutes after it was withdrawn. A total of 1.6 mg hydromorphone was accounted for.

26. Patient 06235 (May 21, 2009): Hydromorphone 0.5 mg IV inj. was ordered for this patient. Respondent removed 1 mg hydromorphone from Accudose at 1009 and did not chart its administration in the patient's eMAR or nursing notes, or record it wasted. Respondent removed 1 mg hydromorphone from Accudose at 1316 and did not chart its administration in the patient's eMAR or nursing notes, or record it wasted. (The patient's pain scale at 1400 was "0.") Respondent removed 1 mg hydromorphone from Accudose at 1530 and did not chart its administration in the patient's eMAR or nursing notes, or record it wasted. The patient was transferred to the operating room at 1318 and then to the Intensive Care Unit. The patient was not in the Oncology Unit at the time Respondent withdrew the last two doses. A total of 3 mg of hydromorphone was unaccounted for.

27. Patient 06224 (May 22, 2009): Hydromorphone 0.3 - 0.5 mg IV inj. was ordered for this patient who was not assigned to Respondent. The patient was discharged at 1409. At 1705, Respondent removed 1 mg of hydromorphone from Accudose and did not chart its administration in the patient's eMAR or nursing notes, or record it wasted. One (1) mg of hydromorphone was unaccounted for.

28. Patient 06211 (May 22, 2009): Hydromorphone 0.3 - 0.5 mg IV inj. was ordered for this patient. Respondent removed 1 mg of hydromorphone from Accudose at 2350 and did not chart its administration in the patient's eMAR or nursing notes, or record it wasted. One (1) mg of hydromorphone was unaccounted for.

29. Patient 06150 (May 23, 2009): Hydromorphone 0.2 mg IV inj. was ordered for this patient. At 1023, this patient's record number was accessed in Accudose, but nothing was recorded removed. At 1024, Respondent recorded 0.8 mg hydromorphone wasted. No administration of hydromorphone was charted in the patient's eMAR or nursing notes.

30. Patient 06211 (May 23, 2009): Hydromorphone 0.3 - 0.5 mg IV inj. was ordered for this patient. Respondent removed 1 mg of hydromorphone from Accudose at 1044 and did not chart its administration in the patient's eMAR or nursing notes, or record it wasted. One (1) mg of hydromorphone was unaccounted for.

31. Patient 01484 (May 23, 2009): Hydromorphone 0.5 - 1 mg IV inj. was ordered for this patient. Respondent removed 1 mg of hydromorphone from Accudose at 1841 and did not chart its administration in the patient's eMAR or nursing notes, or record it wasted. The patient was discharged at 1850. One (1) mg of hydromorphone was unaccounted for.

32. Patient 06150 (May 24, 2009): Hydromorphone 0.2 mg IV inj. was ordered for this patient. Respondent removed 1 mg of hydromorphone from Accudose at 1007 and did not chart its administration in the patient's eMAR or nursing notes, or record it wasted. One (1) mg of hydromorphone was unaccounted for.

33. Patient 06207 (May 25, 2009): Hydromorphone 0.5 - 1 mg IV inj. was ordered for this patient. Respondent removed 2 mg of hydromorphone from Accudose at 2108 and did not chart its administration in the patient's eMAR or nursing notes. Respondent recorded 1 mg wasted at 2109, one minute after it was withdrawn. One (1) mg of hydromorphone was unaccounted for.

34. Patient 06155 (May 26, 2009): Hydromorphone 0.5 mg IV inj. was ordered for this patient. Respondent removed 2 mg of hydromorphone from Accudose at 0410 and did not chart its administration in the patient's eMAR or nursing notes. The patient's pain level was not

charted to justify the administration of hydromorphone. Respondent recorded 1.5 mg wasted at 0412, two minutes after it was withdrawn. One-half (0.5) mg of hydromorphone was unaccounted for.

35. Patient 06240 (June 1, 2009): Hydromorphone 0.5 mg IV inj. was ordered for this patient. Respondent removed 1 mg of hydromorphone from Accudose at 0445 and did not chart its administration in the patient's eMAR or nursing notes, or record it wasted. One (1) mg of hydromorphone was unaccounted for.

36. Patient 06234 (June 2, 2009): Hydromorphone 0.5 mg IV inj. was ordered for this patient. Respondent removed 2 mg of hydromorphone from Accudose at 0446 and did not chart its administration in the patient's eMAR or nursing notes, or record it wasted. The patient's pain scale was charted as "0." Two (2) mg of hydromorphone was unaccounted for.

37. Patient 01639 (June 6, 2009): Hydromorphone 0.5 mg IV inj. was ordered for this patient. Respondent removed 1 mg of hydromorphone from Accudose at 1922 and did not chart its administration in the patient's eMAR or nursing notes, or record it wasted. The patient was discharged at 1933. One (1) mg of hydromorphone was unaccounted for.

38. Patient 06234 (June 7, 2009): Hydromorphone 0.5 mg IV inj. was ordered for this patient. Respondent removed 2 mg of hydromorphone from Accudose at 0210 and did not chart its administration in the patient's eMAR or nursing notes, or record it wasted. The patient's pain level was not charted to justify administration of hydromorphone. Two (2) mg of hydromorphone was unaccounted for.

39. Patient 01083 (June 8, 2009): Hydromorphone 0.5 mg IV inj. was ordered for this patient. Respondent removed 1 mg of hydromorphone from Accudose at 0117 and did not chart its administration in the patient's eMAR or nursing notes, or record it wasted. The patient's pain level was not charted to justify administration of hydromorphone. One (1) mg of hydromorphone was unaccounted for.

40. Patient 06235 (June 8, 2009): Hydromorphone 0.4 mg IV inj. was ordered for this patient who was not assigned to Respondent. Respondent removed 1 mg of hydromorphone from Accudose at 0146 and did not chart its administration in the patient's eMAR or nursing notes, or

record it wasted. The patient's pain level was not charted to justify administration of hydromorphone. One (1) mg of hydromorphone was unaccounted for.

41. Patient 06233 (June 8, 2009): Hydromorphone 0.5 mg IV inj. was ordered for this patient. Respondent removed 1 mg of hydromorphone from Accudose at 1925 and did not chart its administration in the patient's eMAR or nursing notes, or record it wasted. The patient's pain level was "0." One (1) mg of hydromorphone was unaccounted for.

42. Patient 06178 (June 8, 2009): Hydromorphone 1 mg IV inj. was ordered for this patient. Respondent removed 1 mg of hydromorphone from Accudose at 2315 and did not chart its administration in the patient's eMAR or nursing notes, or record it wasted. One (1) mg of hydromorphone was unaccounted for.

43. Patient 01083 (June 9, 2009): Hydromorphone 0.5 mg IV inj. was ordered for this patient. Respondent removed 1 mg of hydromorphone from Accudose at 0024 and did not chart its administration in the patient's eMAR or nursing notes, or record it wasted. One (1) mg of hydromorphone was unaccounted for.

44. Patient 06086 (June 9, 2009): Hydromorphone 1-2 mg IV inj. was ordered for this patient. Respondent removed 1 mg of hydromorphone from Accudose at 0025 and did not chart its administration in the patient's eMAR or nursing notes, or record it wasted. One (1) mg of hydromorphone was unaccounted for.

45. Patient 01809 (June 9, 2009): Hydromorphone 0.1 - 0.4 mg IV inj. was ordered for this patient. Respondent removed 1 mg of hydromorphone from Accudose at 0354 and did not chart its administration in the patient's eMAR or nursing notes, or record it wasted. One (1) mg of hydromorphone was unaccounted for.

46. Patient 00115 (June 9, 2009): No medications were recorded ordered for this patient who had been discharged the previous day, June 8, 2009, at 1646. Respondent removed 1 mg of hydromorphone from Accudose for this former patient at 0355 and did not record it wasted. One (1) mg of hydromorphone was unaccounted for.

47. Patient 01408 (June 14, 2009): Hydromorphone .25 mg IV inj. was ordered for this patient. Respondent removed 2 mg of hydromorphone from Accudose at 0304 and did not chart

its administration in the patient's eMAR or nursing notes, or record it wasted. Two (2) mg of hydromorphone was unaccounted for.

48. Patient 00217 (June 15, 2009): Hydromorphone 0.4 mg IV inj. was ordered for this patient. Respondent removed 1 mg of hydromorphone from Accudose at 2225 and did not chart its administration in the patient's eMAR or nursing notes, or record it wasted. The patient's pain level was "0." One (1) mg of hydromorphone was unaccounted for.

49. Patient 00850 (June 21, 2009) Hydromorphone 0.5 – 1 mg IV inj. was ordered for this patient. Respondent removed 1 mg of hydromorphone from Accudose at 2112 and did not chart its administration in the patient's eMAR or nursing notes. Respondent recorded 0.5 mg wasted at 2113, one minute after it was withdrawn. On June 22, 2009, Respondent removed 1 mg of hydromorphone from Accudose at 2058 and did not chart its administration in the patient's eMAR or nursing notes. Respondent recorded 0.5 mg wasted at 2100, two minutes after it was withdrawn. The patient's pain level was "0." A total of one (1) mg of hydromorphone was unaccounted for.

50. Patient 06233 (June 22, 2009): Hydromorphone 0.3 – 0.5 mg IV inj. was ordered for this patient. Respondent removed 1 mg of hydromorphone from Accudose at 2225 and did not chart its administration in the patient's eMAR or nursing notes, or record it wasted. The patient's pain level was "0." One (1) mg of hydromorphone was unaccounted for.

Division of Investigations (DOI) Contact With Respondent

51. In an interview with Respondent on October 13, 2010, Respondent told the DOI investigator that she received an orientation on LLUMC's protocols and procedures, and that all of the hospital's policies and procedures were available on the hospital's computers and could be accessed by all staff.

52. Respondent told the investigator that she never took Diluadid from the Accudose station without administering it to the patient. Respondent told the investigator that this incident was the first time she had been disciplined about her documentation, however her LLUMC personnel file indicates that Respondent was verbally counseled on June 24, 2008, regarding her failure to document her patient care. On June 18, 2008, it was reported that Respondent did not

record Intake and Output (I&O) on any of her patients for an entire shift, there were no orders noted or followed through, and only two narratives were documented for an entire day on one patient. Respondent was directed that in the future, if she felt overwhelmed, to seek help from her peers and the charge nurse so as to avoid compromising patient care. On July 16, 2008, Respondent was verbally counseled after she failed to chart medication administration to a patient on July 13, 2008. Respondent was admonished that charting the administration of medications was important to prevent medication overdose. Respondent's excuse was that she forgot to sign them off and that she would pay more attention to detail in the future.

53. Respondent denied diverting narcotics but could offer no plausible explanation for the missing hydromorphone other than the Accudose report was incorrect.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

54. Respondent has subjected her registered nurse license to disciplinary action for unprofessional conduct under section 2761, subdivision (a), in that during the period from May 16, 2009 to June 22, 2009, while employed by LLUMC (as detailed in paragraphs 12-53 above), Respondent repeatedly removed controlled substances from Accudose and failed to properly document her handling of the narcotics in the hospital's eMAR, medical records, or Accudose. Respondent failed to properly document wastage, removed more medication than was ordered or necessary, and removed medication that was not ordered. Respondent removed medication for patients with a pain level of "0." Respondent further withdrew medications for patients who were not assigned to her, and withdrew medications for patients who had been discharged or transferred from her unit. Respondent's actions demonstrated unprofessional conduct in that she repeatedly failed to provide nursing care as required by failing to properly chart and record medication administration.

SECOND CAUSE FOR DISCIPLINE

(Illegal Possession of Controlled Substances)

55. Respondent has subjected her registered nurse license to disciplinary action under section 2762, subdivision (a) of the Code for unprofessional conduct in that on multiple occasions, as detailed in paragraphs 12-53, above, Respondent obtained and possessed in violation of law controlled substances taken from her employer.

THIRD CAUSE FOR DISCIPLINE

(Inaccurate Documentation in Hospital Records)

56. Respondent has subjected her registered nurse license to disciplinary action under section 2762, subdivision (e) of the Code for unprofessional conduct in that on multiple occasions, as described in paragraphs 12-53, above, Respondent falsified, or made grossly incorrect or grossly inconsistent entries in hospital, patient, and Accudose records pertaining to controlled substances prescribed to patients.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 298775, issued to Marion Elaine Gamundoy, also known as Marion Elaine McGinn;

2. Ordering Marion Elaine Gamundoy to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 5/5/11

LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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